California's Integrated Core Practice Model for Youth and Family

Primer Series 5— Transitioning and Care Coordination

The California Integrated Core Practice Model for Children, Youth, And Families

Goals for Today

- *Identify Relevant Transition and Care Coordination Practice Standards*
- *Discuss Key Factors in Effective Transition and Care Coordination for Foster Youth*
- *Identify and discuss how the state's Integrated Core Practice Model guides effective care in this area.*

Introduction and Background…

- This is a ***primer*** in best practices for care coordination and transition planning, sometimes referred to as Case Management or Care Management.
- Focus on **professional behaviors** which create high quality care outcomes for foster youth, rather than the rules we've created to support care management.
- While information sharing is central to Care Coordination activities, this primer does not seek to address issues or discuss privacy/confidentiality issues in any substantive way.

California's Foster Serving systems are not alone in seeking better care coordination--

- **39.5 million hospital discharges per year at costs totaling $329.2 billion!**
- **Healthcare case management is not standardized:**
  - Loose Ends/"after thoughts"
  - Communication Issues
  - Poor Information
  - Poor Preparation
  - Fragmentation
- **19% of patients have a post-discharge aftercare episode (Problem with Care Access)**
- **20% of Medicare patients readmitted within 30 days.**
- **California Systems currently delivering MH care to +/-23% of Foster youth**

What is Care Coordination?

- "…patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services." [1]
- Care coordination synchronizes the delivery of a patient's health care from multiple providers and specialists. The goals of coordinated care are to improve health outcomes by ***ensuring that care from disparate providers is not delivered in silos***, and to help reduce health care costs by eliminating redundant assessments and procedures.

What is a Transition?

- Sometimes oversimplified to "Discharge Planning"
- Applies to any and all moves or changes in care placement, level of care, or provider assignment.
    - Placement in a new STRTP facility
    - New Social Worker or ICC Care Coordinator
    - Placement in a different county/host county
    - Change in therapist or physician
    - Change in Foster Care placement
    - Other Changes in Care Responsibility

Four Elements Of Coordinated Care

1. Clear and easy access to necessary services and the providers capable of delivering those services.
2. **Good communication** and effective **care plans/transitions** between providers and care managers.
3. Effective information sharing based in client needs, not in fear of privacy or confidentiality laws.
4. A focus on the total health care needs of the Foster Youth. Clear and simple information that youth and family can understand.

Does your Transition planning process provide these?

Why Care Coordination matters?

Receiving services from different public agencies creates major obstacles and challenges for youth and caregivers and is also a barrier for providers. (Katie A.)

At least 50% of CA's foster involved families need a service provided by a parallel or secondary system.

More than 25% of youth will be served by at least one additional county (Out of County)

Closes the gaps in access, coordination, information sharing and service delivery.

(System of Care)

State-MHP Guidance: Specialty Mental Health Services:

- "The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners (including the mental health client plan, and plans from child welfare, special education, juvenile probation, etc.) are integrated to comprehensively address the identified goals and objectives, and that ***the activities of all parties involved with service to the child or youth and/or family are coordinated to support and ensure successful and enduring change.***"
- "…intended to ***link beneficiaries to services provided by other child-serving systems;*** to facilitate teaming; and to coordinate mental health care. If a beneficiary is involved with two or more child-serving systems, MHPs should utilize ICC to facilitate cross-system communication and planning."

--Medical Documentation and Billing Guide, 2017

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ALL COUNTY INFORMATION NOTICE (ACIN) NO. I-21-18
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES (MHSUDS) INFORMATION NOTICE (IN) NO. 18-022
May 18, 2018

California's Integrated Core Practice Model

"Provides specific expectations for best practices in child welfare, juvenile probation, mental health, and community partners as they work ***collaboratively*** to serve the child, youth, and family members and/or caregivers in achieving their goals."

Integrated Core Practice Model Elements

- Engagement
- Assessment and Service Planning
- Monitoring and Adapting
- **Transitioning**

Planning includes a discussion about what resources will be needed for purposeful transition out of formal services. This might include a potential mix of formal and natural supports in the community.

The focus on transition is continual during the CFT process, and the preparation for transition is apparent even during the initial engagement activities.

Services are not closed until the transition plan has been implemented and all necessary connections for the future have been made.

ICPM Element Four: Transitioning

ICPM Transition Behaviors (Enhanced)

- "When it is known that a member(s) of the CFT will change, work with the team to plan how to support the new member(s) to come up to speed quickly, understanding their role, and what has been accomplished.
- When placement or permanency plan changes are necessary, work to ensure that the CFT agrees with the plan, or, at a minimum, understands why a decision is being made; create **proactive safety and support plans to ensure successful transitions.**
- Involve the family's formal and informal support systems to prepare for life after formal care is no longer involved.
- *Make sure that any referrals for continuing care or supportive resources are in place and working* ***before the transition is complete.***

Care Coordination Key Questions

- Has our youth's referral information been received?
- Have you received all necessary Health, Education or related records to begin care?
- Has our youth been engaged by the new service provider(s)?
- Has our youth been seen for her/his intake or first service session?
- Do you have a CFT scheduled or are you/your provider aware of current CFT schedule?

When Transitions are poorly managed--

- ***Bad or ineffective transitions re-traumatize youth and their families***
  - ***More Crises/Emergency Room visits***
  - ***More use of Inpatient Psychiatric Care***
  - ***Higher costs to payers and insurance companies/County Systems***
  - ***Increased number of lost School Days***

A word about "Out of County" Care management--

- *AB 1299 seeks to close gaps in Coordination of Care between two counties.*
- *The law, by itself, cannot improve our practice.*
- *While organizations support and assure effective Care management, the actual process is a function of human, professional behavior.*

(In other words—People/professionals have responsibility for good transitions and care coordination)

- *Don't let the law obscure or distract you from your ethical obligation to not abandon a client or leave them unclear about their care delivery and service options.*

Relationships > Rules

“Organizational Culture Eats Strategy for Lunch”

Effective Transitions benefit agencies and providers

- Reduces costs associated with crisis management
- Reduces time spent "fixing" effects of interrupted care.
- Less time in IPC meetings
- Reduces costs and risks associated with flight behavior (AWOL)
- Increases job satisfaction (Happy Consumers)

Organizational "Transition Support" Processes

- *Interagency Master MOU to concretize Care Coordination for Multi System Youth*
- *Interagency Management or Leadership Meetings*
- *Cross Training of CWS, MH and Probation Staff with Transition Duties*
- *Use Supervisory Time to review transition related behaviors and outcomes*
- *Recognize and reward success*
- *Hold selves and others to shared accountability (CFT)*
- *System Improvement, Performance Improvement and Case Review Oversight Processes (See Next Slide)*

Care Coordination CQI--SIP/PIP

Step 1: Make a clear and decisive statement and get ownership for change

Step 2: Appoint team leader

Step 3: Constitute SIP/PIP implementation team

Step 4: Analyze current transition process and readmission rate

Step 5: Establish goals. What is the target readmission rate? What percentage of foster youth will be seen for first service episode in what time frame?

Step 6: Establish timelines for Improvement

Step 7: Identify the target population

Step 8: Decide how to fulfill the role of ICC Coordinator or Transition manager

Step 9: Identify approach for follow up phone calls

Plan Do Study Act (PDCA)

Most Important Takeaways

- *Transitions of Care are the single biggest challenge for many foster youth and their families.*
- *Effective transition services require professionals to take extreme care and often "extra effort" to assure that appropriate services are in place or secured immediately.*
- *Legislation, law or rule won't fix this…only* **we** *can fix this!*